Student Dependent Certification Form

TUFTS Health Plan

Subscriber's name: _____

Subscriber's Tufts Health Plan ID number: _____

I certify that: _____ ___-___-___ _____

(Name of student dependent) (Social Security Number) (Date of Birth)

is my or my spouse's *unmarried child who:

(Please check one)

❑ **Is currently a FULL TIME STUDENT** (as defined by the educational institution)

At: _____ (Name of accredited educational institution)

_____ (Institution address)

_____ (Institution City, State and Zip)

_____ (Registrar's telephone number

for the Spring/Fall (Circle One) _____ (Year) Semester

which begins _____ and ends _____

Expected date of graduation: _____

❑ **Is no longer a full-time student**

I further certify that the information I have provided above is true and correct, and that I understand that:

- **I must notify Tufts Health Plan immediately if there is any change in my dependent's student status; i.e., a change from full-time to part-time status, a transfer to another school, dropped out of school or this dependent gets married.**
- **Tufts Health Plan may contact the educational institution and take any other steps it feels necessary to verify the accuracy of the information I have provided.**
- **If there is any misrepresentation in the information I have provided, Tufts Health Plan may end my dependent's coverage and my whole family's coverage, and may seek any other legal remedies available.**

- **My dependent's coverage will be ended without any additional notice if I do not return this form within 30 days.**

Subscriber's signature:_____ Date: _____
(**Must be Employee's signature**)

Please return this completed and signed form by mail or fax to:

Tufts Health Plan
Commercial Enrollment and Premium Billing Department
Attention: Student Verification
P. O. Box 9186, Watertown, MA 02471-9186
Fax number 617-923-5898